CNIC Health Solutions®
A Rocky Mountain Health Plans TPA
www.cnichs.com

Flexible Spending Department
6251 Greenwood Plaza Blvd., Suite 300,
Greenwood Village, CO 80111-4913
Telephone (303) 770-5710–Option 9
Toll Free: 800-426-7453
Fax (303) 770-0380 OR (303) 749-1185
E-mail: flex125@cnichs.com

FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT REQUEST CLAIM FORM

Please Complete all Information Applicable to Your Request

CITY OF CASPER, #11101140

Employee Name: _____ Date: _____
SS# or Employee ID#: _____
Change of Address: _____

I hereby certify that this reimbursement request meets the requirements of Section 213 of the Internal Revenue Code. **The attached services were incurred while I was eligible for benefits and during the Flex Plan Year. I also certify that these expenses are not eligible for reimbursement under any other health plan, and that I have not been reimbursed, nor will I seek additional reimbursement for these expenses.**

Signature: _____

Unsigned forms will be returned.

Guidelines for Claim Submission:

Reimbursement requests must include the following:

- ❑ Name, Tax ID or Social Security number, and address of the Provider of Service for daycare expenses.
- ❑ Type of Service and itemization of charges, including dates of service. **(No balance due statements**)
- ❑ Only IRS eligible expenses that are not eligible for reimbursement under any health plan should be submitted for reimbursement. **Insurance MUST process the expenses prior to being eligible for Flex reimbursement.**
- ❑ Reimbursement requests must be incurred during your time of eligibility and submitted no later than 90 days after the end of the Flex plan year or within 90 days from your termination date.
- ❑ **Late claims cannot be considered for reimbursement.**
- ❑ Keep a copy of all claims submitted for your records. We are unable to return submitted items.

*****PLEASE SEE REVERSE FOR CLAIM FILING INSTRUCTIONS*****

UNREIMBURSED MEDICAL EXPENSES

Request Total: $ _____ Date(s) of service from: _____ to: _____

(Attach **copies** of insurance statements and itemized bills)

DAYCARE REIMBURSEMENT EXPENSES

Request Total: $ _____ Date(s) of service from: _____ to: _____

(Attach **copies** of receipts)

Dependent Care Provider: _____

Social Security /Tax ID Number of Provider: _____

Child's Name: _____ Age: _____

Fax, E-mail OR Mail reimbursement request to:
CNIC Health Solutions-Flex
PO Box 3559
Englewood CO 80155-3559

Flex Customer Service:
Nationwide (800) 426-7453
Local (303) 770-5710
Fax (303) 770-0380 OR (303) 749-1185
E-mail – flex125@cnichs.com

FLEXIBLE SPENDING ACCOUNT
CLAIM FILING INSTRUCTIONS

1. Please complete the claim form in full and attach copies of all receipts, invoices, or Explanation or Benefit (EOB) statements. Documentation must clearly indicate:
    - Date services incurred or supplies purchased
    - Name and Address of the provider of services or supplies
    - Name of the person receiving the service or supply
    - Type of expense
    - Amount of Expense
    - Total amount paid by any insurance company

2. If any insurance company did not or will not reimburse you for ANY portion of an expense that you are submitting, please mark across the top of the invoice or receipt "NOT PAID BY INSURANCE" and initial it. If it is an expense that is part of your deductible, a copy of the EOB which indicates that, must be attached.

3. **DO NOT SEND CANCELED CHECKS OR STATEMENTS THAT ONLY INDICATE BALANCE DUE. THESE DO NOT SUPPLY THE REQUIRED INFORMATION.**

4. Claims submitted without the necessary information will be denied and a letter sent to the claimant. This may cause a significant delay in processing reimbursement checks.

5. For daycare claims, submit receipt from daycare provider showing that you have paid for the care. Include dates of service, Social Security or Tax ID number of the caregiver. This must be included on every claim.

6. Keep copies of supporting documentation for your records. We will not return what has been submitted.

7. **Over the Counter Drugs.** For over the counter medications to be eligible expenses under the Plan, they must be for the diagnosis, prevention or treatment of a specific medical condition and not merely for the overall good health of the participant. Dietary supplements, cosmetics and sundry items are not reimbursable. Please submit a cash register receipt (must indicate the specific name of the medication) and circle the eligible items for reimbursement.

INELIGIBLE EXPENSES

Expenses not eligible for reimbursement through the Health Care Spending Account include, but are not limited to, the following:

Charges for no-shows/missed appointments	Dietary supplements, diet food	Premium payments for health coverage
Contact lens insurance	DNA collection	Rogaine and other hair growth stimulants
Controlled substance in violation of federal law	Electrolysis	Service or Administrative fees
Cosmetic surgery	Finance Charges	Vitamins
Cosmetics – Deodorant	Funeral expenses	Teeth bleaching
Diapers or Diaper service for newborns	Holistic & natural remedies	Massage therapy (unless prescribed by physician to treat a specific injury or trauma)